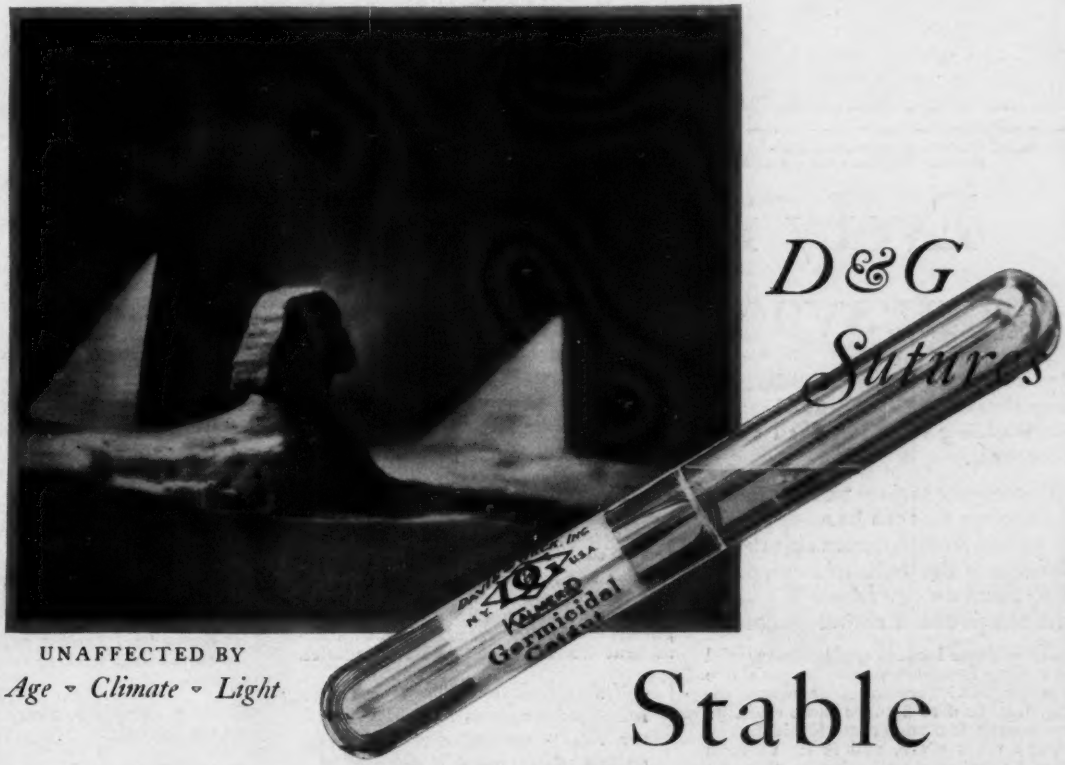
THE Canadian Hospital

A Monthly Journal for Hospital Executives

Toronto, Can. | *The Edwards Publishing Company* | May, 1927



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In This Issue—

Lay Anaesthetists in the Hospital
Scope for Economy in Hospital Building
Qualifications of the Dietitian
News of Hospitals and Staffs

The wick of Cellucotton Absorbent Wadding (on the right) is drawing the fluid against gravity, distributing it throughout the entire wick. The other absorbent becomes wet but a short distance from the surface, obviously material is wasted.

Every inch absorbs! . . . no extravagant waste of material

IF you base economy on initial cost, remember this—Cellucotton Absorbent Wadding costs less than other absorbents.

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And—if you look to savings in material for savings in money—examine the above photograph. Cellucotton Absorbent Wadding absorbs 4 to 8 times more drainage than cotton, it retains more liquid before leakage takes place, and it draws fluid *against* gravity—distributing it over the entire dressing instead of absorbing it only in one spot. Consequently, fewer dressings are necessary for the same amount of work.

It is this three-way economy of Cellucotton Absorbent Wadding *plus* its far greater usefulness that has earned it an exclusive place as standard dressings material in the majority of American and Canadian hospitals.

We have prepared a folder describing 5 simple comparative tests which show in detail the reasons for the superiority of Cellucotton Absorbent Wadding. On receipt of a post card we'll gladly send it free, together with a generous, usable sample of this fine absorbent.

Ask also for your free supply of Kotex and Celluwipes—two finished products of Cellucotton Absorbent Wadding. They possess all the features of Cellucotton Absorbent Wadding—and all its economies.

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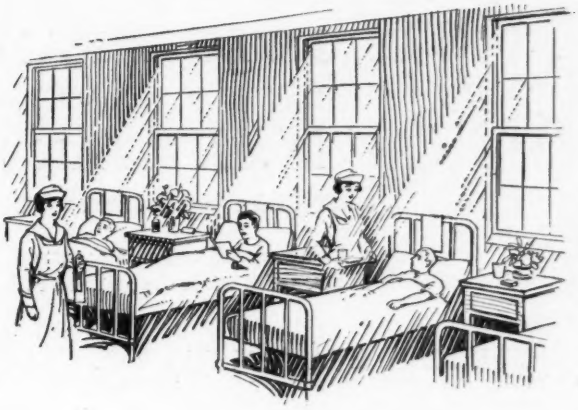
CELLUCOTTON ABSORBENT WADDING

Please refer to THE CANADIAN HOSPITAL when writing

VIORAY

The Health-Giving Glass

AN announcement was recently made introducing VIORAY, a clear vision window glass which permits the passage of the ultra-violet rays. Already the medical profession is realizing the great value of this glass for the hospital, the sanitarium and the sickroom.



There is no need to elaborate on the curative effects of the ultra-violet rays in the treatment of tuberculosis, catarrh, rheumatism, neuritis, skin diseases, St. Vitus dance and many other ailments. It is a well known fact that these rays accelerate the healthy growth of children, prevent the development of rickets, increase resistance to infection and speed the healing of wounds.

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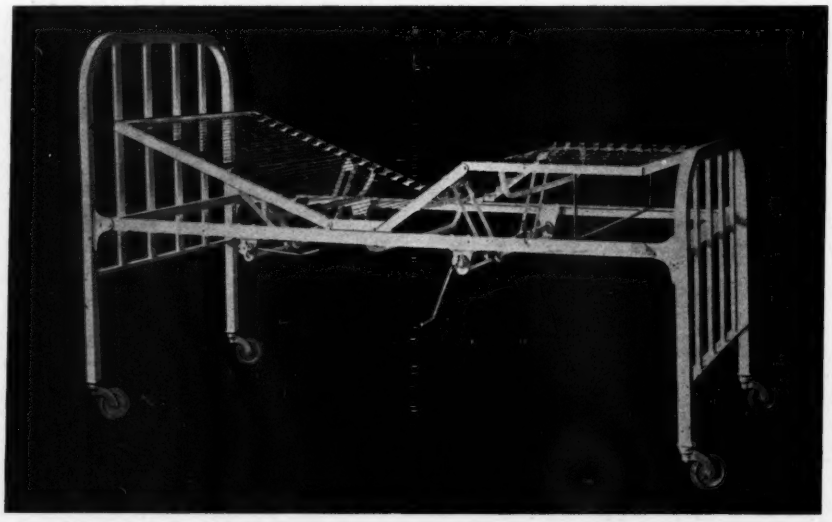

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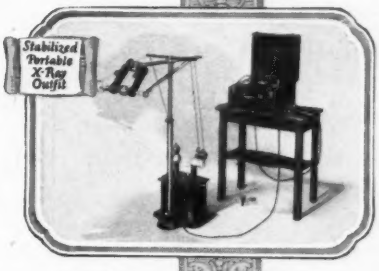

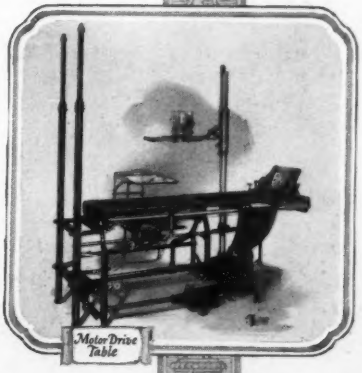

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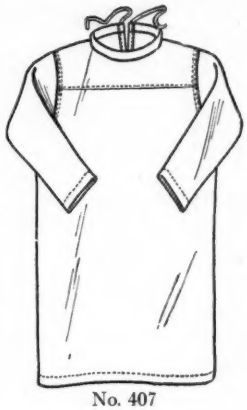

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Accounting Methods Not Adequate

Many hospitals, and especially the smaller ones, have done themselves an injustice in their methods of bookeeping.

Various items which should be included in the cost of maintenance are omitted. In a bulletin issued by the Ontario Hospital Association, entries covering the following items are suggested:

All moneys received should be accounted for, as these sums are used again in the making of necessary purchases and should go into the cost of maintenance. In the same way, all gifts in materials should be entered at current market prices, and treated as cost of maintenance. Similarly, with interest on endowments when used in the purchase of needed supplies. Interest on borrowed funds and repairs to buildings should also be entered into the cost column. Then the impairment on goods, clothing, furnishings, apparatus and buildings should be added to the cost account. Linen and bedding deteriorate twenty per cent. per year; instruments, apparatus and furnishings, ten per cent. yearly; frame buildings should be written down five per cent., brick buildings, two per cent., and steel construction buildings, one per cent. yearly.

By such a method as this the actual cost of running each hospital would be shown. The result of such a method of accounting would reveal a per diem cost per patient much higher than that shown in the government returns.

Automobiles Add to Expenses

The hospitals of Britain are complaining of a new cause of expense which, to some extent, is reflected in this country. Leeds, that great manufacturing city in Yorkshire, has several large hospitals. They have always been called upon to give free treatment in a large number of industrial accidents, particularly in their woollen and clothing mills. Now it is reported in Leeds that accidents due to traffic mishaps increased from 700 in 1925, to 900 in 1926. It is observed that rather less than half of these cases are such that the patient has to be detained, but the temporary care and treatment of transient cases are fairly costly and have piled up the charge upon the clinical treasury. The patients actually hospitalized must pay their way, but the others are given free treatment. That is common to British and European hospital service.

Patients in Canadian hospitals suffering from minor injuries are usually charged for dressings and treatment, and in some cases patients, being unable to pay, are given free treatment. Those more seriously injured, and unable to pay, present the greater problem.

The Leeds hospital authorities suggest three remedies and they are now under consideration. The first suggestion made is that all motorists should be obligated to take out casualty insurance and that such insurance should be made to cover suitable hospital charges for treatment of victims. The second is that the municipality, being responsible for the traffic, should also be responsible for the cost of the institutional treatment of the injured. And the third is that the cost of treatment should be borne by the road fund.

Keeping Unsterile Articles in their Place

It has been recognized that where provision is not made in hospitals for two separate rooms, one for unsterile articles and the other for sterile articles, that it is possible that an unsterile packet may be taken into the operating room by mistake, believing the packet to be sterile, which would naturally bring about infection. The following is a simple, inexpensive method of dealing with such a contingency:

In making up the packets for sterilizing, insert in

each packet, where it would be seen immediately upon opening the packet, a small card about 1½"x½". On this card is written with sterilizing ink, the formula of which appears below, the date on which the package is prepared. This ink when written is red in color, and after sterilizing is a brownish-black. Thus on opening a package in the operating room the nurse in charge is in a position to immediately detect whether or not the dressings have been through the sterilizer. In the centre of each drum is a Diack Control. This Diack Control fuses at 260 degrees temperature. The sterilizing ink is not for the purpose of guaranteeing that the article is sterile, but merely to indicate that the articles have been through the sterilizer. The Diack Controls may be purchased from any of the surgical supply houses. The ingredients for sterilizing ink may be procured from any reputable chemist at a nominal cost. Following the operation, the name of the patient and the date of operation is written with ordinary ink on the back of the card and kept for reference for one month. This simple method gives the operating room supervisor a sense of security, in that if the surgeon at any time following the operation claims that the operating room is at fault for the infection, the card may be referred to, indicating that at least the surgical supplies were not responsible for the infection. This method, with periodical bacterial examinations of catgut, etc., places the operating room technique in a comparatively safe position.

Sterilizing Ink.—Silver nitrate, 1 oz.; potassium bitartrate, 1 oz.; liq. ammon. fort., 4 ozs.; sacch. alba (white sugar), 2 drams; pulv. acasia, 2 drams; analin magenta, ½ dram.

Storing X-Ray Film in Safety

One of the peculiar characteristics of nitro-cellulose X-ray film is that of decomposition, or flameless combusion, at a relatively low temperature, so that besides being inflammable the gases of decomposition are explosive, although in a physical sense nitrocellulose film is not an explosive.

Two general conditions have been observed in practically all the film fires that have occurred; with inadequate or insufficient ventilation or an opportunity for the gases to get to the outer air, the vault or receptacle containing the decomposing film becomes practically a gas generator and evolves large volumes of combustible gas which will ignite of its own accord, and burn with an extremely hot and vicious flame.

Recommendations of the National Board of Fire Underwriters for the storage and handling of nitrocellulose film are as follows:

All film should be kept in vented cabinets or in a vented storage room.

Vented Cabinets

(a) No cabinet shall exceed 30 cubic feet capacity.

(b) Cabinets shall be of approved insulated construction.

(c) Cabinets having a capacity in excess of 200 pounds of film shall be divided into at least two distinct compartments; each compartment provided with an independent door and vent. The separating partitions should be practically air-tight and be of substantial construction equivalent to the sides.

(d) Cabinets holding over 100 pounds of film shall be equipped with at least one automatic sprinkler in each compartment unless each compartment holds less than 30 pounds of film, and the construction is such that fire will not extend from one compartment to another.

(e) Each compartment shall be provided with a vent to the outside air. The vent shall have a cross-sectional area of at least one square inch per cubic foot of capacity of the cabinet.

Filing cabinets and safes have recently been introduced in Canada in designs suitable for the storage and safekeeping of X-ray film, and which have vents to allow free circulation of air. The adoption of these in hospitals should do much to lower the fire risk.

Thank God every morning when you get up that you have something to do that day which must be done, whether you like it or not. Being forced to work, and forced to do your best, will breed in you temperance and self-control, diligence and strength of will, cheerfulness and content, and a hundred virtues which the idle never know.—Charles Kingsley.

Dr. George David Stewart, M.D., F.A.C.S.

President-elect of the American College of Surgeons

Some of the most prominent physicians have come from the less-known parts of the world. George David Stewart, for instance, was born in Cumberland County, Nova Scotia, December 28, 1862, the son of Daniel and Mary J. (McCallum) Stewart.

He received his preliminary education in his own country, at Teachers' College, Truro, N.S., and at St. Francis Xavier College. But when he took up his medical studies he went to the United States and entered Bellevue Hospital Medical College, of New York University, from which he was graduated as a Doctor of Medicine in 1889.

The next year he married Ida M. Robb, of Antigonish, Nova Scotia, and entered Bellevue Hospital as an interne.

That Dr. Stewart's work was of a high order is attested by the fact that, after some years, he was made Professor of Surgery in Bellevue Hospital Medical College.

The Doctor has been a helpful if not exceedingly prolific contributor to medical literature, his papers dealing with surgical subjects, especially gastroenterology.

At its recent session, at Toronto, the American College of Surgeons testified to Dr. Stewart's professional accomplishments by electing him their president for the coming year.

LAY ANAESTHETISTS IN THE HOSPITAL

By DR. J. L. ALLEN, Calgary

Dr. John Snow, an English physician, the first specialist in anaesthesia, entered his career as the result of a chance meeting. The story runs that one day as he was leaving the hospital he met a druggist whom he knew bustling along with a large ether apparatus under his arm. "Good morning," said Dr. Snow. "Good morning to you, doctor," said the druggist, "but don't detain me. I am giving ether here, there and everywhere, and am getting quite an ether practice. Good morning, doctor." "Rather peculiar certainly, for the fellow hasn't the remotest clinical or physiological knowledge," thought Dr. Snow.

To John Snow we owe much for developing many of the fundamental principles of anesthesia. Our problem to-day is not the druggist, but the trained nurse as anaestheist. Some of them may be competent, but how many of them can properly interpret some of the phenomena we all observe in the course of an anaesthetic? If the general public—yes, and the medical profession too—could only recognize that some of the dangers and much unnecessary suffering could be avoided by skilled judgment in anaesthesia, our problem would be simple, but unfortunately it is not recognized that a good deal of the post-operative discomfort and dangers are due to the anaesthetic and the way it is managed.

The answer to our problem is a matter of publicity and education, not legislation. It is quite useless to pass laws making it illegal for anyone not licensed to practice medicine or dentistry to give anaesthetics, unless public sentiment supports it. If you doubt this statement, let me call your attention to the difficulty of enforcing the late liquor law.

A well-known surgeon once said if he were going to be operated on his first question would be, "Who is going to be my anaesthetist?" The apprehension which the layman experiences regarding his anaesthetic is only too well known and the majority fear this part of the operation more than the operation itself. In spite of this, this important task is often entrusted to some underling who pursues his work unconscious of its importance. If the surgeon himself were the patient, he wouldn't tolerate this, and it seems only fair that when patients trust their lives to a surgeon that he should at least practice the golden rule.

Thorough Knowledge Necessary

Now, the practice of any specialty implies a preliminary thorough ground work in general medicine. In spite of this fact the administration of an anaesthetic is often entrusted to individuals who have never seen the inside of a medical school. Now, assuming that anaesthesia is a specialty, it is hard to understand why the lay preson, after more or less instruction in anaesthesia, should be allowed to practice this specialty. It would be just as logical for a non-medical individual to become a competent ophthamologist or gynaecologist.

P. G. Flagg, in his "Art of Anaesthesia," says: "How can a lay person intelligently form an opinion on such vital matters as acidosis, toxaemia, carbon-oxide, stimulation and depression?" How can he unravel and relieve the untoward symptoms which might arise in a case complicated by respiratory obstruction, morphine depression and reflex inhibition? No one can deny that these factors must constantly be uppermost in the mind of the anaesthetist if he is really in earnest about his work, but earnestness does not imply medical education."

There is one other medical specialty practiced extensively by non-medical individuals and which can be given here in comparison, namely, obstetrics. We all know of the havoc wrought by the midwife. The medical profession is beginning to realize the gravity of permitting poorly trained women to attend maternity cases. Shall the practice of anaesthesia be permitted to be practised by those who are not competent?

Principle Is Wrong

No, the principle of lay anaesthetists is wrong. I am quite aware that those who favour this practice cite some of the large American clinics. It is hard to understand why the heads of these clinics, who go to great trouble and expense to get experts to administer their different departments, should employ lay persons in one of their most important departments. After all it is a matter of education and I look for the time in the not far distant future when all hospitals will employ only medical anaesthetists. We have now the Anaesthetic Research Society and the Canadian and American Society of Anaesthetists, and it is hoped that their efforts may so educate the public and the profession that a higher type of anaesthesia will be brought about.

One hestitates to suggest that any hospital employing the lay anaesthetist does so with pecuniary motives, but any hospital which employs unqualified anaethetists leaves itself open to the possibility of serious criticism.

Some of the medical schools have already instituted a chair of anaesthesiology, which is a very encouraging sign that the subject is beginning to be recognized by university authorities as an important one. When all universities institute a chair of anaesthesiology, the subject will be universally recognized as an important one and then the lay anaesthetist will disappear, but in the meantime we must go our way quietly and by means of educative measures and a high quality of work convince the profession and the public that there is no place for the layman in this important branch of medicine.

In the matter of fees this work is underpaid, with the result that good students who would make good anaesthetists shun this specialty for surgery or something else that offers better financial return. When the profession and the public realize the importance of this subject and fees commensurate with its importance are paid we will get a higher type of anaesthetist, with much benefit to our patients.

From an address given to a conjoint convention of the Alberta Association of Registered Nurses, The Alberta Hospitals' Association and The Alberta Municipal Hospitals' Association at Calgary, November 23rd, 1926.

Will Add Roof Garden to Hospital

That interest on the part of the London, Ont., War Memorial Children's Hospital committee in the advancement of the hospital, has not flagged, was happily demonstrated when the committee practically pledged themselves to the building of a roof garden at the institution.

This was discussed as an important part of hospital equipment. Dr. Harold Little, of the staff, and Miss Grace Fairley, superintendent, who spoke, both stressed the fact that sunshine, fresh air and running water were the prime factors in the care of the sick and the prevention of disease. Each year sees new discoveries and new development in methods of treatment, and with these the committee means to keep abreast as far as is possible.

While some points in modern equipment are lacking at the Memorial Hospital, in others it outstrips many other institutions.

Dr. Little stressed the need for increased plumbing accommodation to permit of running water in each cubicle, a system not included in the original estimates. He noted the splendid addition of the cubicles which have been installed by the committee, and which, he stated, go a long way toward solving one of the important problems of children's hospitals, that of cross-infection. Dr. Little noted the rapid growth of the hospital attendance, which is now over sixty, and referred to the committee as the "business end of the institution" backing and supporting the medical staff in their work. This increase in attendance necessitates some enlargement of facilities, and with this in mind, the committee will secure estimates for the additional plumbing required, and also for the roof garden.

The latter is an interesting piece of equipment which will retain for the child patients every possible ray of sunshine, and will add materially to the efficiency of the treatment.

NATIONAL HOSPITAL DAY MAY 12

How Shall the Day Be Observed?

The purpose of National Hospital Day is to teach the public the scope and value of hospital service—to demonstrate what the hospital is doing for the community and what moral and financial aid it needs in order to continue its present service and reach out into new fields.

Get your community acquainted with your Hospital.

War Memorial Children's Hospital, London, Ont.

Late Mrs. N. H. Bull Left Large Estate

An estate totalling $239,951 is disposed of by the will of the late Mrs. N. H. Bull, widow of the late Thomas Henry Bull, K.C., Toronto.

The Gravenhurst Sanitarium receives $20,000 for the maintenance of the B. Frank Bull cottage, and $2,000 is bequeathed to the Hospital for Sick Children to endow a Thomas Bull cot.

Maria Wells, a sister, is bequeathed $3,000, and Miss Mary E. Good, niece, receives the income from $10,000, of which, on her death, $4,000 goes to the Hospital for Incurables and $2,000 each to the Women's Missionary Society of the Methodist Church, the Superannuation Fund and the Deaconess Training Home.

Another niece, Agnes Good, receives the income from $4,000, which on her death is to be divided equally between the Salvation Army and the Upper Canada Tract Society.

Clara Good, niece, inherits the income of $10,000, which on her death goes to the Aged Women's Home, the Aged Men's Home, each of which received $3,000; the Methodist Union, Toronto, and the W.M.S. of Central Methodist Church, each of which receives $2,000.

The Home Mission Department of the Methodist Church in Canada is bequeathed $10,000 to establish the Thomas Henry Bull fund as a memorial to her deceased husband, the income to be used to support a home misisonary.

Tag and Smile Bring $502

How a $2 tag and the smile of a happy tag-day salesgirl brought $500 to Montreal Children's Hospital, is revealed in the will of Frederick Black, who died on March 28, aged 60, in the Memorial Hospital, New London, Conn.

Up to his death he preserved the tag, purchased for $2 from a young girl on the street during a visit to Montreal, and frequently exhibited it to his friends, talking of the incident with much feeling. The sequel was found when Max Boyer, attorney, of New London, and Mr. Black's executor, opened the will and revealed a bequest of $500 to the Children's Hospital.

Mr. Black was an expert insurance adjuster and had made his headquarters at the Mohican Hotel, New London, for a score of years. He was a New Zealander and had no known relatives.

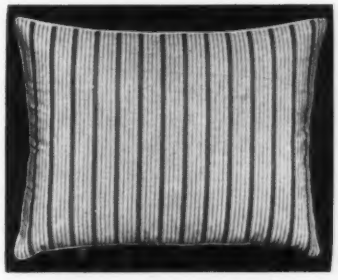
Toronto's New Ambulance Service

A new development in ambulances is now at the disposal of the physicians of Toronto. The chassis is on a long wheel base so that the stretcher can be placed in the ambulance either through a side or rear door. The patient is carried on a special cot fitted with a hood so that the face is shielded from the public and can be completely covered when weather conditions demand. The interior of the ambulance is equipped with running water. It has two attendants and can be procured at any hour.

New—Different—Better

TWO PILLOWS IN ONE

DOUBLE ARC — DOUBLE FILLED



The inner casing is filled with coarse feathers to supply body and sustained resiliency. The outer casing is filled with finer feathers or down to give the softness of the down cushion. The inner and outer section of the pillow is cut in such a manner as to at all times form a natural double arc — an engineering principle that prevents flattening and skimpness. The filling is at all times forced and held into its proper relative thickness throughout the pillow or cushion.

Use the Canfealine Double Arc Pillow and

Give Your Patients This Added Comfort

The Superior Construction of

"Perfect" Feather Spring Mattresses

Not only insures longer service and greater economy, but builds goodwill by giving restful, soothing comfort to the patient.

If your dealer does not handle, write us

The Canadian Feather & Mattress Co.
LIMITED

Toronto Ottawa

We Keep Awake that Others may Sleep

SCOPE FOR ECONOMY IN HOSPITAL BUILDING

By H. P. VAN ARSDALL
Samuel Hannaford & Sons, Architects, Cincinnati

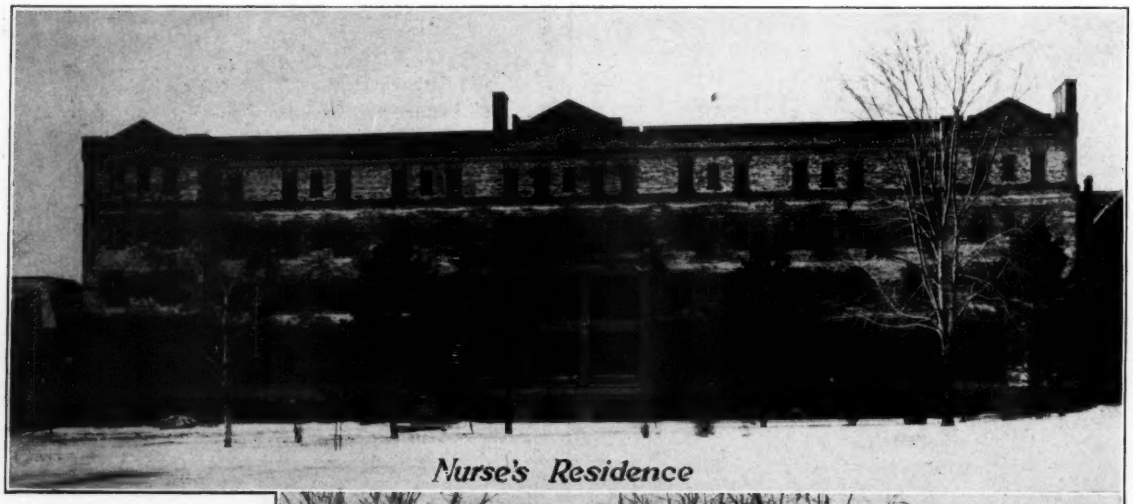
Within the last few years the cost of building construction has advanced much more rapidly than the cost of living (the natural gauge of hospital charges) and consequently it is only through the most careful and painstaking planning that hospitals can be constructed within reasonable limits of cost. The architect seldom has unlimited means at his command for, generally speaking, the building programme is much more ambitious than the funds available warrant and for that reason the architect must plan carefully, must have a full knowledge of hospital administration and medical technique, and must utilize to the utmost every available cubic foot of space.

The average hospital in the middle west is costing between 68 cents and 75 cents per cubic foot complete with all necessary built-in and attached equipment, not including, however, furnishings and movable equipment. This price is based on well planned and economically designed buildings. Building committees are often told that hospitals will cost so much per cubic foot or so much per patient bed. Both of these figures are misleading unless you consider them together. An architect may design a building with all rooms oversized, which would result in a low cubic foot price and a small bed capacity. On the other hand, with all rooms undersized, your cost per cubic foot would be excessively high but bed capacity large.

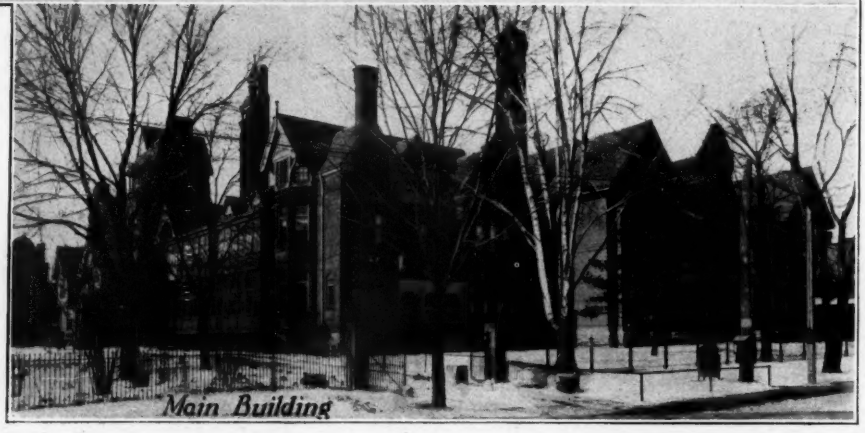
Because economical consideration in hospital operation may not be overlooked, the building must be designed to fit the service like a comfortable shoe. The various departments must not only be so correlated as to eliminate unnecessary traffic and excess help, but they must be neither too large nor too small. Either fault means increased operating cost through increased personnel or in vexatious hindrances to essential service. In arriving at a fair estimated cost per cubic foot, your calculations should therefore be based on well proportioned room sizes, giving a maximum bed capacity with easy accommodation of the various services.

Few building committees realize that for every extra cubic foot of space added to the size of a room

Read before the American Hospital Association at Atlantic City, N. J., Sept. 27—Oct. 1, 1926.



Nurse's Residence



Main Building

The Toronto Hospital for Incurables, Dunn Ave., showing the Main Building and the Modern Nurses' Residence.

an additional 68 cents has to be raised, and it is at this point that one of the principal economies in hospital planning can be exercised. In visits to various hospitals, old and new, throughout the United States, I have found many private patient rooms 12 feet wide by 17 feet long, with ceilings ranging in height from 10 to 12 feet. A room of this size, 12x17x10 feet, contains 2,040 cubic feet. This is far in excess of present-day requirements. Most of our state laws require a minimum cubic foot allotment of approximately 1,000 cubic feet for private patient's room, and good practice demands between 1,400 and 1,500 cubic feet. I believe it is agreed by many hospital consultants and architects that a room 10′ 2″ wide x 15′ 6″ long is ample in area for the best private room. However, the question of ceiling height is little discussed and it is this that I want to call to your special attention. Assume that your floor area, 10′ 2″ x 15′ 6″ is correct. To arrive at a cubage of 1,450 feet your ceiling should be approximately 9′ 2″ high. Suppose, however, the architect made a ceiling 10′ 0″ high instead of 9′ 2″; there would be a clear loss of 132 cubic feet, or approximately $89.76 per room. But do not lose sight of the fact that when you raise a ceiling in one room this same height must extend throughout the floor. Imagine having a hospital 45′ 0″ wide x 200′ 0″ long, which is an area of 9,000 square feet; now increase the height of your ceiling one foot. Do you know that you have added 9,000 cubic feet, or an additional cost of approximately $6,120, and at the same time added forever an increased upkeep cost for cleaning, painting and heating? Now, suppose you have six floors of bedrooms, you have increased your building costs approximately $36,720. You no doubt will say that your architect should know better—he should, but by visiting some of the new hospitals in the nearby vicinity you will find that this statement is true. The matter of ceiling heights is a very important one and should never be neglected in the study of planning problems.

Concealed Piping

I can cite other instances. Take the kitchens in many of our institutions and you will find ceilings ranging in height from 12 to 16 feet. No doubt the reson for this is the exposing of steam and plumbing pipes, and heat and vent ducts. When a kitchen is properly planned and equipped, heat and vent ducts and pipes of all sorts should be eliminated entirely from the ceiling, not only to save the excessive ceiling height, but for the purposes of cleanliness and neat appearance. Pipes carrying steam, gas and water may be run in furred spaces on the ceiling below, while the vent ducts from ranges can be drawn down underneath the floor and discharged vertically through a shaft to the roof. With the absence of pipes from the kitchen ceiling the height may be cut down to a minimum of 11 feet.

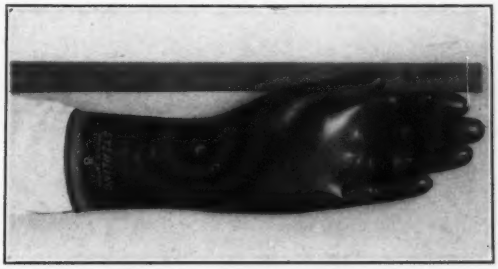
I must digress for the moment to defend the statement just made regarding the concealment or running of pipes in furred spaces which is a radical departure from usual practice. Some twenty odd years ago our leading hospital consultants and architects invariably exposed all steam piping throughout their buildings

Continued on Page 14

Sterling

SURGEON'S GLOVES

Long Gauntlets: Comfort, Protection



The extra long gauntlet coming well over the sleeve and reinforced at the end is a Sterling feature found in few, if any other, surgeon's gloves.

No need of the mind being distracted by the loose cuffs of the gown, when they are enclosed in Sterling Surgeon's Gloves.

Sterling Rubber Company
LIMITED
GUELPH - CANADA
Largest Specialists in SEAMLESS Rubber Gloves in the British Empire.

Economical—

TRISEPTOL

"HARTZ"

Is more than three times as powerful a germicide as Pure Carbolic Acid

Pathological tests have demonstrated the efficiency of Triseptol conclusively.

TRISEPTOL is freely soluble in water, is not caustic and not nearly so toxic as Carbolic.

TRISEPTOL on account of its high germicidal power is most economical.

TRISEPTOL is manufactured in CANADA
BY

The J.F. HARTZ Co.
LIMITED
Pharmaceutical Manufacturers
TORONTO MONTREAL

3 People out of 4 Have Foot Trouble

IT IS estimated that 70% to 80%, or about three-quarters of the shoe-wearing public, suffer from some form of foot trouble, says the "Boot and Shoe Recorder"

Flexible Like Your Foot

Are you one of them?

The time to correct most shoe ills, it points out, is when the shoes are obtained. *By getting correctly made shoes which fit properly.*

Isn't that reasonable? True, anyway. The

Cantilever Shoe

gives such wonderful foot comfort to most people because it is made to fit the foot naturally.

It is flexible from toe to heel. The arch curves in to fit the hollow of the foot. The toes have room. The heel-fit is snug and comfortable.

MAIL ORDER SERVICE

If it is not convenient for you to visit one of the stores listed below, write to the Toronto branch. Mail orders receive careful attention.

Cantilever Shoe Shops

Note New Agencies:

TORONTO—7½ Queen St. East
HAMILTON—8 John St. North
MONTREAL—Keefer Bldg., St. Catherine St. W.
OTTAWA—241 Slater St., Jackson Bldg.
BRANTFORD—Ludlow Bros.
SAINT JOHN, N.B.—Scovil Bros., Limited
HALIFAX—Wallace Bros.
SUDBURY—F. M. Stafford, Limited
WINNIPEG—Hudson's Bay Company
SASKATOON—Royal Shoe Store
PORT ARTHUR—McNulty's Limited
REGINA—Yale Shoe, Limited
EDMONTON—Hudson's Bay Company
CALGARY—Hudson's Bay Company
VANCOUVER—Hudson's Bay Company
VICTORIA—Hudson's Bay Company

Scope for Economy in Hospital Building

Continued from Page 13

and would not permit them to be installed in any other way. Mechanical practice has proved beyond a doubt that when low pressure piping is properly installed and of the right materials it can be concealed with only a remote possibility of leaks. In the use of concealed piping some precautions should be taken, and as a safeguard it is advisable to install at convenient points in the furrings small flush metal access panels or inspection doors, which give an easy means of detecting leaks and the making of quick repairs. We find concelaed piping installed in practically every other type of large building, and I can see no good reason why we should continue an obsolete practice in hospital construction that is an eyesore, unsanitary and expensive.

Regarding waste of cubic contents, we find the same condition existing in major operating rooms, many of which are 18 feet wide by 24 feet deep, with ceilings 11 to 16 feet in height. Why these excessive sizes I do not know, since for all practical purposes a major operating room 16x20 feet with an 11-foot ceiling is sufficient. These rooms, as you know, are to-day equipped with mechanical ventilation, and lighting units which are heatless, so there can be no good reason for such extravagance. For years major operating rooms have been equipped with large and expensive skylights and steel sash. These are not only expensive in the original construction cost, but are a constant source of expense for upkeep. The majority of present-day surgeons are constantly operating under artificial light, and if you are willing, the cost of the skylight construction can be easily omitted with a consequent large saving.

Plan Building to Fit Equipment

In the planning of room arrangement and the spotting of the various units in any hospital structure, you should insist that the architect, at the time of making sketches for the building, lay out every piece of furniture in the different units so that all waste space can be saved. This portion of the work requires the most careful study and should be thoroughly worked out in the sketch stage. On the other hand a more serious loss can be had if the units are planned too small, since this will hamper your entire plan of management and operation. Seldom will you go wrong if you make your architect plan the equipment locations at the time of planning the building. If your architect is unable to do this then he is unfit to undertake your problem.

The planning of a hospital is not a simple matter. Indeed it is considered by the architectural profession the most highly technical problem than an architect has to solve. I have attempted to explain in a practical way how architects and building committees can, in all good faith and with the best of intentions, unknowingly spend many thousands of dollars that might, by careful planning, have been saved.

We now come to another interesting problem, and that is the selection of materials. I propose to discuss only those materials that enter into the construction of a fireproof building, as any other type of construction

(Continued on Page 19)

GUY DE CHAULIAC (1300-1368) was the first to take the operation for hernia from the hands of strolling mountebanks. He rendered his patients stuporous by inhalations of vapor from sponges containing lettuce, opium, hemlock and other drugs and dipped in hot water. In herniotomy he sought to promote fibrosis, one of his methods being to constrict the sac with a silk ligature, knotted securely over a superimposed block of wood, and allowed to remain until it cut through.

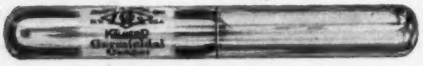
D&G Sutures

"THIS ONE THING WE DO"

DAVIS & GECK INC.

Kalmerid Catgut

GERMICIDAL. Exerts a bactericidal action in the suture tract. Supersedes the older unstable iodized sutures. Impregnated with the double iodine compound, potassium-mercuric-iodide.† Heat sterilized.



The boilable grade is unusually flexible for boilable catgut; the non-boilable grade is extremely flexible.

TWO VARIETIES

BOILABLE* NO.		NON-BOILABLE NO.
1205	PLAIN CATGUT	1405
1225	10-DAY CHROMIC	1425
1245	20-DAY CHROMIC	1445
1285	40-DAY CHROMIC	1485

Sizes: 000..00..0..1..2..3..4

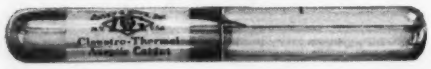
Approximately 60 inches in each tube

Package of 12 tubes of a size.....$3.00

Less 20% on gross or more or $28.80, net, a gross

Claustro-Thermal Catgut

ASEPTIC—not germicidal. Sterilized by heat after the tubes are sealed. Boilable.* Unusually flexible for boilable catgut.



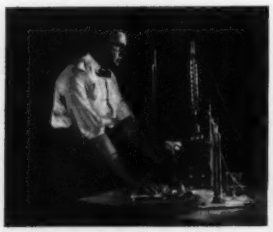
NO.	
105	PLAIN CATGUT
125	10-DAY CHROMIC CATGUT
145	20-DAY CHROMIC CATGUT
185	40-DAY CHROMIC CATGUT

Sizes: 000..00..0..1..2..3..4

Approximately 60 inches in each tube

Package of 12 tubes of a size.....$3.00

Less 20% on gross or more or $28.80, net, a gross

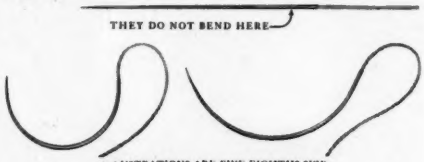


D&G Sutures are always found neutral under the most delicate titration tests. This is one of the reasons they uniformly behave well in the tissues.

Atraumatic Needles

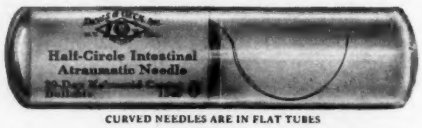
FOR GASTRO-INTESTINAL suturing and for all membranes where minimized suture trauma is desirable. Integrally affixed to 20-day Kalmerid catgut. Boilable.*

Experimental evidence has proven 20-day chromic catgut the most suitable for gastro-intestinal suturing. It has been found that gastric wounds are fully healed within 12 days, and intestinal wounds at 16 days. At these periods the 20-day catgut (regardless of size) still retains, respectively, 60 per cent and 30 per cent of its initial strength.



ILLUSTRATIONS ARE FIVE-EIGHTHS SIZE

STRAIGHT NEEDLES ARE IN ROUND TUBES



CURVED NEEDLES ARE IN FLAT TUBES

NO.		INCHES IN TUBE	DOZEN
1341	STRAIGHT NEEDLE	28	$3.00
1342	TWO STRAIGHT NEEDLES	36	3.60
1343	⅜-CIRCLE NEEDLE	28	3.60
1345	½-CIRCLE NEEDLE	28	3.60

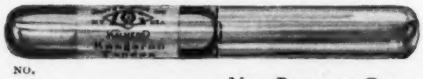
Less 20% discount on one gross or more

Sizes: 00..0..1

Packages of 12 tubes of one kind and size

Kangaroo Tendons

GERMICIDAL, being impregnated with potassium-mercuric-iodide.† Chromicized to resist absorption in fascia or in tendon for approximately thirty days. The non-boilable grade is extremely flexible.



NO.	
370	NON-BOILABLE GRADE
380	*BOILABLE GRADE

Sizes: 0..2..4..6..8..16..24

Each tube contains one tendon

Lengths vary from 12 to 20 inches

Package of 12 tubes of a size.....$3.00

Less 20% on gross or more or $28.80, net, a gross

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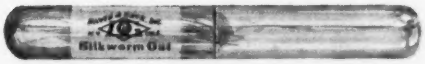
D&G Sutures are obtainable from responsible dealers everywhere; or direct, postpaid

Non-Absorbable Sutures



NO.		INCHES IN TUBE	SIZES
350	CELLULOID-LINEN	60	000, 00, 0
360	HORSEHAIR	168	00
390	WHITE SILKWORM GUT	84	00, 0, 1
400	BLACK SILKWORM GUT	84	00, 0, 1
450	WHITE TWISTED SILK	60	000 TO 3
460	BLACK TWISTED SILK	60	000, 0, 2
480	WHITE BRAIDED SILK	60	00, 0, 2, 4
490	BLACK BRAIDED SILK	60	00, 1, 4

BOILABLE

Package of 12 tubes of a size.....$3.00
Less 20% on gross or more or $28.80, net, a gross

Short Sutures for Minor Surgery

NO.		INCHES IN TUBE	SIZES
802	PLAIN KALMERID CATGUT	20	00, 0, 1, 2, 3
812	10-DAY KALMERID "	20	00, 0, 1, 2, 3
822	20-DAY KALMERID "	20	00, 0, 1, 2, 3
862	HORSEHAIR	56	00
872	WHITE SILKWORM GUT	28	0
882	WHITE TWISTED SILK	20	000, 0, 2
892	UMBILICAL TAPE	24	⅛-IN. WIDE

BOILABLE

Package of 12 tubes of a size.....$1.50
Less 20% on gross or more or $14.40, net, a gross

Emergency Sutures with Needles

UNIVERSAL NEEDLE FOR SKIN, MUSCLE, OR TENDON

NO.		INCHES IN TUBE	SIZES
904	PLAIN KALMERID CATGUT	20	00, 0, 1, 2, 3
914	10-DAY KALMERID "	20	00, 0, 1, 2, 3
924	20-DAY KALMERID "	20	00, 0, 1, 2, 3
964	HORSEHAIR	56	00
974	WHITE SILKWORM GUT	28	0
984	WHITE TWISTED SILK	20	000, 0, 2

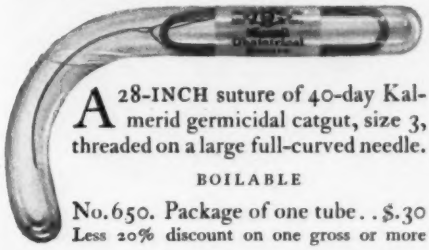
BOILABLE

Package of 12 tubes of a size.....$2.40
Less 20% on gross or more or $23.04, net, a gross

The ash of D&G Sutures is assayed to make sure that no traces remain of uncombined chromium nor of other residues of the chromicizing process.

Obstetrical Sutures

FOR IMMEDIATE REPAIR OF PERINEAL LACERATIONS



A 28-INCH suture of 40-day Kalmerid germicidal catgut, size 3, threaded on a large full-curved needle.

BOILABLE

No. 650. Package of one tube..$.30
Less 20% discount on one gross or more

Circumcision Sutures

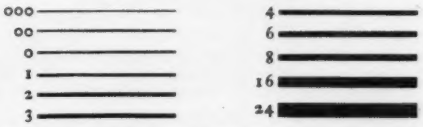
A 28-INCH suture of Kalmerid germicidal catgut, plain, size 00, threaded on a small full-curved needle.

BOILABLE

No. 600. Package of 12 tubes.....$3.00
Less 20% on gross or more or $28.80, net, a gross

Universal Suture Sizes

All sutures are gauged by the standard catgut sizes as here shown



*These tubes not only may be boiled but even may be autoclaved up to 30 pounds pressure, any number of times, without impairment of the sutures.

†Potassium-mercuric-iodide is the ideal bactericide for the preparation of germicidal sutures. It has a phenol coefficient of at least 1100; it is not precipitated by serum or other proteins; it is chemically stable—unlike iodine it does not break down under light and heat; it interferes in no way with the absorption of the sutures, and in the proportions used is free from irritating action on tissues.

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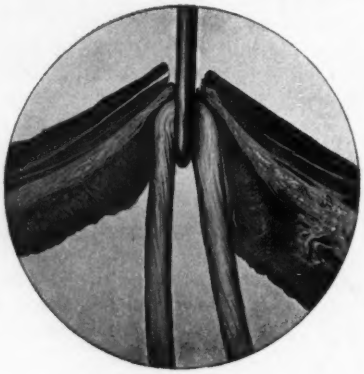
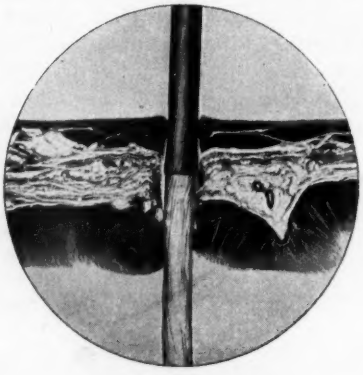
MINIMIZED SUTURE TRAUMA



ORDINARY NEEDLE

Photomicrograph of ordinary intestinal needle penetrating the stomach wall. Note excessive trauma produced by the doubled catgut.



ATRAUMATIC NEEDLE

Photomicrograph prepared under identical conditions, of the D&G Atraumatic Needle with suture attached. Note minimized trauma.

D&G ATRAUMATIC NEEDLE

Affixed to the Boilable Grade of 20-Day Kalmerid Germicidal Catgut

FOR GASTRO-INTESTINAL AND MEMBRANE SUTURING

IN PACKAGES OF TWELVE TUBES OF ONE KIND AND SIZE

PRODUCT NO.		DOZEN TUBES
1341.	A straight intestinal needle affixed to a 28-inch suture.....	$3.00
1342.	Two straight intestinal needles affixed to a 36-inch suture.....	3.60
1343.	A 3/8-circle intestinal needle affixed to a 28-inch suture.....	3.60
1345.	A half-circle intestinal needle affixed to a 28-inch suture.....	3.60

SIZES: 0 AND 1

20 PER CENT DISCOUNT ON A GROSS OR MORE—POSTPAID

DAVIS & GECK INC. ▾ 211-221 DUFFIELD STREET ▾ BROOKLYN, N.Y., U. S. A.

Scope for Economy in Hospital Building

Continued from Page 14

should be prohibited by law. The average architect or building committee seldom errs in the selection of brick, stone or terra cotta, but by judicious care in the choice of some of these and other materials many savings may be made

Where the concrete skeleton type of building is employed, you will understand that the exterior walls are usually constructed 13 inches thick, that is, the first 4 inches of thickness consists of an impervious face brick, the other 9 inches being of hard-burned common brick. Good practice teaches us that the 9-inch thickness may be constructed of a hollow tile back-up block since the wall is for enclosing purposes and supports only its own weight from floor to floor. At the same time the hollow tile will act as an insulator against heat and cold. One some of our recent work we have made a saving of one-half of one per cent. on the entire cost of the building by the use of this material.

The practice of using sloped tops on cases, refrigerators, lockers, etc., is undesirable, in my opinion, as it is cheaper and more sanitary to furr in their heads. We often find doors to the patients' bedrooms equipped with three tumbler locks, door knobs, escutcheons, and checks. These are expensive and noisy in operation. The use of an arm hook on the room side of the door, together with a friction thumb latch will not only be less expensive, but will do away with noise. In addition to the arm hook the door should be provided with a door check, a flush pull on the corridor side and a lock that may be used when the room is unoccupied. On all closet doors use only one knob and that on the room side.

Blanket, solution and bed pan warming closets should be of the built-in type and made a part of the original construction work.

One of the largest items of expense in any hospital is wall tile. We find it used as wainscoting in kitchens, utility rooms, serving pantries, treatment rooms, operating, sterilizer and scrub-up rooms, and in all toilets and baths. For the sake of economy, tile wainscots in kitchens, utility, treatment, bath and toilet rooms need not be run higher than five feet. In operating rooms it is probably better to extend it to

Continued on Page 20

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NITROUS OXIDE
ETHYLENE
OXYGEN

in Any Size Cylinder

QUEEN CITY DENTAL MANUFACTURERS
LIMITED
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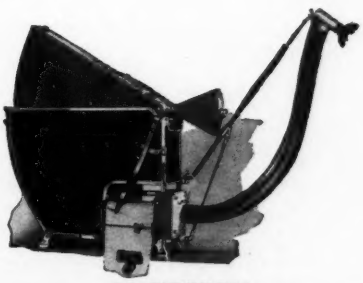
THYROID DISORDERS

Affecting Basal Metabolism



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RECORDING METABOLOR
An Important Diagnostic Instrument

THIS instrument records the rate of metabolism in ink, producing a permanent record of the test and showing those characteristics of respiration which are essential to a perfect reading. It may be used anywhere and embodies every element necessary for a diagnostic instrument of this sort.

For further details, directions, etc., write

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2226-36 ASHLAND AVENUE, TOLEDO, OHIO
Manufacturers of Gas-Oxygen Machines, the Metabolor and Surgical Pump

"This Is Station KSC"

Keever StarchCo.
Columbus, Ohio

Broadcasting the Greater Economy and Superiority of Satin Finish Sizing.

SINCE its first introduction a few years ago, Satin Finish and the Satin Finish way of sizing RAW **over the wheel** has been adopted by a majority of the hospitals in the United States and Canada. No other starch can be substituted that will give the original new appearance, "invisible stiffness" and greater strength to the fabrics of coats, aprons, uniforms, caps, gowns, etc. They are not **made** to do that. Satin Finish was developed **specifically** to provide a Textile Mill Sizing **suitable** for Laundry work. We wanted Satin Finish to **replace** the **original** mill sizing which the first washing **removes.** It does just that—**puts back** the sizing and **restores** the fabric to its **original** new state.

Now "stand by" one minute while you **write us** a postcard request for a **FREE** 3-pound sample bag.

Scope for Economy in Hospital Building

Continued from Page 19

a height of seven feet. The greatest economy, however, that can be made is in the selection of the material itself. There are three grades of tile—"Select," "Standard" and "Commercial." The "Select" grade costs approximately $1.90 per square foot, the "Standard" $1.80 and the "Commercial" $1.50. "Select" tiles are without flaws and should be used only in operating rooms. The next grade, "Standard," permits of small inaccuracies in manufacture, but of such a nature as the layman would not detect. These may be used in sterilizer, treatment, toilet and baths throughout, while the third grade, "Commercial," is easily acceptable for kitchens and utility rooms. It is not unusual to find that your architect has specified all tile to be of the "Select" grade which is, of course, an extravagance, as a large saving can be made when the cheaper tiles are used.

Piping to Suit Requirements

This same practice can be employed in every branch of the work, for instance: All hot water lines throughout your building should be of brass (iron pipe size), as this material will last a lifetime and will free you from piping repairs. We often find that in order to go ahead with a project hospital authorities are willing to use galvanized wrought iron pipe instead of the brass in order to save on the first cost. It has been my experience that on hot water lines wrought iron pipe will last about six years, then leaks develop and you are put to a large expense not only for plumbing repairs, but the expense of ripping out floors, partitions, etc. The additional cost for brass is slight and wherever possible it should be used. On cold water lines you will be perfectly safe in using the galvanized wrought iron pipe.

Fire lines or stand pipes may be made of steel, as the water in these remains stationary except in case of fire. Pipes carrying high pressure live steam may be made of extra heavy steel, but always use genuine wrought iron where pipes carry condensed steam. The use of the steel pipe will effect a saving of approximately 25 per cent. on the cost of the material. In connection with the plumbing fixtures there is a waste pipe which runs to the basement sewer and a vent which extends to the roof. In buildings of two stories and over, the waste and vent pipes are usually made of genuine galvanized wrought iron. This is necessary in the case of the waste pipe, but the vent line may be made of galvanized steel instead of iron. Saving on this one item amounts to about seven per cent. on the average hospital plumbing job.

Where acids are used in such rooms as the laboratory and pharmacy, all waste lines should be made of acid-resisting pipe, else you will come to early grief. Recent reports of the Research Committee of the American Society of Sanitary Engineers recommend the use of acid-resisting pipe on kitchen wastes. In the purchase and selection of electric and plumbing fixtures, use only those best suited for the purpose intended, then buy the best quality. Plumbing fixtures are constantly in use and unless built for hard service you will experience much trouble.

In the purchase of finishing hardware such as

latches, knobs, escutcheons, push plates and hinges, a slight saving can be effected in the kind of material used. Nearly all hospitals are equipped with cast bronze or brass material, whereas a substantial reduction can be made in the cost if you use cast brass or bronze for all exterior openings and for the interior doors, cast iron or steel finished in "Bower Barff," which will be just as serviceable and as good to look at.

I shall not go into the matter of boilers, laundry and sterilizing equipment. The field is well occupied by numerous dealers and manufacturers of specialties, the merits of which depend very largely at least on the user's point of view and on his familiarity with the apparatus. Suffice it to say that first cost should not be the first consideration. The machine which does its work at the least expense per unit of output is the more economical regardless of price. The higher cost is soon absorbed by cheaper operation.

The time allotted for the reading of this paper is too short for a lengthy discussion of the proper planning of facilities to meet only operating needs.

Luxuries Not Necessities

If building costs are to be held to a minimum we must omit from our building programmes such things as utility facilities connecting with each private room; private baths for a large portion of the private patients' rooms; special metal cabinets and cupboards in private rooms, and so on. These facilities are luxuries, and of course are desirable, but we must not educate our people to believe that every hospital constructed must of necessity have them. It seems to me that we should strongly discourage the inclusion of such specialties, unless the hospital is the possessor of unlimited means. The time has come when those having building operations in charge should give ample time to the study of hospital planning and aid their architect in every way possible towards a proper solution of the problem.

Friendly Co-operation Necessary

In conclusion, let me say that an architect is primarily a master builder and that his principal function is building. The information which he brings to the solution of the hospital problem is necessarily acquired by contact with superintendents, supervisors, physicians and surgeons, and others, and from observation in many similar institutions, and is therefore a composite of many minds.

He may well be counted as authority in such matters. Nevertheless, each project is a separate problem; local practice, preponderance of one class of service over others, personal bias of operating bodies or persons, are all to be taken into consideration and successful developments are to be achieved only by the friendly co-operation of all those most nearly concerned. There is an old adage which says, "There is wisdom in a multitude of counsellors," but the other aphorism should not be forgotten, namely, "Too many cooks spoil the broth."

Using the New Vioray Glass

TORONTO.—The Sick Children's Hospital are glazing the verandah of the infants' ward with the new Vioray glass, the clear vision commercial window glass which permits the passage of the ultra-violet rays.

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News of Hospitals and Staffs

A Condensed Monthly Summary of Hospital Activities, Building and Extension Plans and Personal News of Hospital Workers.

OTTAWA, ONT.—By the will of the late John McKinney, resident of Ottawa, whose death occurred on March 22 last, the Ottawa Civic Hospital will receive $5,000 and the Salvation Army a like amount.

* * *

MACKLIN, SASK.—At a cost of more than $75,000, a thirty-bed hospital has been completed at Macklin, Sask., and equipment installed. It was ready for the reception of patients on April 8. The citizens of Macklin and district are proud of this institution which has sprung up since last October when building activities commenced.

* * *

SMITH'S FALLS, ONT.—For the second time in eight years, fire, on April 2, caused considerable damage to the public hospital here, burning the roof through in several places and destroying the flag tower. The origin of the fire has not been determined. Several patients on the second floor were safely removed to other quarters.

* * *

SYDNEY, N.S.—Miss E. M. Campbell, R.N., of North West Arm, who for the past six years was matron of Harbour Hospital, Sydney Mines, will be the new matron of Bairncroft. This appointment was made at a meeting of the Bairncroft executive, presided over by President John A. Young. Miss Bray, former matron, was compelled to resign owing to ill health.

* * *

TORONTO, ONT.—For a population of 556,691 Toronto has but 2,170 hospital beds, an average of 3.8 per 1,000 population, as compared with an average of 10 per 1,000 prevalent in most American cities. Ottawa and Hamilton are far ahead of Toronto in this respect, the former having an average of 13 and the latter 8.2 per 1,000. When the contemplated additions to the General and Western Hospitals are completed the average will even then be only approximately 5 per 1,000.

* * *

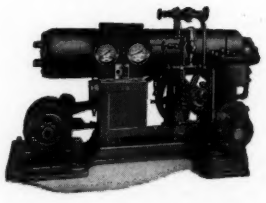
MONCTON, N.B.—The Moncton Hospital Board has accepted the offer of the city council to guarantee $75,000 worth of bonds, the proceeds of the sale of which are to be utilized in the construction of additional hospital facilities for the public of Moncton and the adjoining districts. The Board also decided to ask the city council to appoint three members to the building committee and to invite the medical men of the city to appoint two members of their society to confer with the Board and Miss A. J. MacMaster, the superintendent, regarding plans for the extension.

VICTORIA, B.C.—Appointment of a successor to Miss Jessie Mackenzie, late director of nursing at the Provincial Royal Jubilee Hospital, was made by the board of directors on April 5. Miss A. F. (Lena) Mitchell, R.N., who has been acting director since January, has received the appointment, and Miss A. S. Dec. O'Grady, R.N., formerly of Winnipeg General Hospital, was appointed assistant matron.

* * *

MONTREAL, QUE.—Official announcement of a campaign to raise a fund of $4,000,000 for the Royal Victoria Hospital and the Montreal General Hospital (with which are amalgamated respectively the Montreal Maternity and the Western Hospital) was made on April 12 in a statement signed by Sir Vincent Meredith, as president of the Royal Victoria, and Col. Herbert Molson, as president of the Montreal General. The actual campaign will cover the six days from Monday, April 25, to Saturday, April 30, both dates inclusive.

QUALITY YORK SERVICE



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REGINA, SASK.—The cost of an addition to the Regina General Hospital was set at $121,485 when a tender for this amount was approved by the city council on the recommendation of the city commissioners and the Hospital Board. Plumbing and heating installations will cost an additional $14,900, and partitions, wall fixtures, etc., another $20,000.

* * *

MONCTON, N.B.—Dr. F. A. Richard, roentgenologist at Moncton City Hospital, has returned from Chicago, where for several weeks he took a special course in physiotherapy and advanced X-ray treatment in the Cook County Hospital and at the headquarters of the Victor X-ray Company in that city.

* * *

EDMONTON, ALTA.—Miss Fern Stacey, daughter of Mr. and Mrs. J. E. Stacey, of 11115 Eighty-fifth Avenue, has been appointed dietitian at the Ponoka Mental Hospital, and has assumed her duties. Miss Stacey graduated in household economics from the University of Alberta in 1924, and later took pupil dietetic training at the University Hospital. Since completing this training she has been employed in the Physiatric Institute, Morristown, New Jersey. The appointment of a dietitian at the mental hospital is one in which many have been keenly interested for some time, and the announcement of Miss Stacey's appointment will be welcome news.

* * *

MONTREAL, QUE.—The appointment of Sir Arthur Currie as McGill representative on the joint committee of the Montreal General and Royal Victoria Hospitals, and the naming of Dean C. F. Martin of the medical faculty of the university on the medical advisory council to that joint committee, constituted the chief items of business at a meeting of the board of McGill governors held on April 4. Another appointment was that of Dr. Frank Pedley as lecturer at McGill in industrial hygiene. Dr. Pedley is a graduate of McGill in Arts and Medicine. He has had considerable experience in public health work with large corporations and is now at Columbia University as a lecturer, from where he comes to McGill.

* * *

TORONTO, ONT.—Several transfers amongst the executives of Ontario mental hospitals were announced at the Parliament Buildings by Hon. Lincoln Goldie, Provincial Secretary. The changes have been made necessary by the recent appointment of Dr. E. J. Ryan, who had been superintendent of the Kingston hospital, to the position of director of mental hospitals. Dr. W. M. English, who has been superintendent of the Hamilton hospital for the past eighteen years, has been transferred to Brockville. The Hamilton hospital in turn is to be administered by Dr. J. J. Williams, who has been identified with the Woodstock hospital for twenty-two years. The Woodstock hospital is to come under the charge of Dr. T. J. Cumberland, who has been assistant superintendent at Brockville.

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MONTREAL

Notes on Ultra-Violet Therapy

By J. C. ELSOM, M. D., Madison, Wis.
Director of Physical Therapy
University of Wisconsin Medical School

For a great many years I have been interested in photography. I have exposed thousands of sensitized films and plates to the action of light, coming through a photographic lens, the light being admitted for a fraction of a second—sometimes 1/25, 1/50, 1/100, or even 1/1000 of a second. The light is admitted by the momentary opening of a shutter. I have taken these exposed plates and films to my dark room, and under the non-actinic rays of the ruby light, the film appears quite unchanged. There is not the slightest visible effect of the light; but there has been a change, somewhere, somehow.

We consider photography a simple process. That is because it is so common, so easy. But there are intricate chemical changes that have been produced by the light on the sensitized emulsion which coats the celluloid film or the glass plate. These chemical changes are precise and accurate and permanent. The strong light of the sky has deeply impressed itself on the film; the half tones, or weaker lights, have not left such a pronounced effect, and the deep shadows, or weakest lights, have hardly affected the film at all. These variations in intensity are what make the picture. There must be contrast in lighting.

What has happened to this film? Physicists and chemists attempt to explain in high-sounding phrases, but after all the real reason of the change is quite inexplicable.

If I leave this film in my camera for six months or even longer, I notice that it is still quite unchanged, so far as my eye, or the most delicate microscope can detect; but the chemical effects of the actinic rays are still there, in spite of the fact that they cannot be seen.

Now I mix up a few chemicals in my glass graduate. I take some water, add a substance which is called a developer, which may be pyrogallic acid, or one of a dozen other oxidizing agents; then a little sodium sulphite, sodium carbonate, and perhaps a small quantity of postasium bromide. I pour this mixture on my plate or film. In a few seconds, or minutes, I notice that in places the film is growing dark; in other places not so much so. But an image is appearing, very dark where the light has struck, very light where the shadows were. Some of the emulsion has not been affected at all. My friend's black hat has not affected the film; his red necktie, also, has left no impression. His yellow shoes impress my film very slightly. If he wears an orange band on his hat (which he ought not to), it likewise does not show in my negative. Standing beside him is a girl with a blue dress, a purple ribbon and a bunch of violets. These appear very strongly on my film. What does that mean? The colors at the lower end of the spectrum, the red and orange and yellow, are non-actinic. Their wave lengths are long, too long for actinic effect. But the girl is wearing colors at the upper end of the spectrum—blue and purple and violet; these colors have very short wave lengths. We call them actinic. They impress themselves on my plate. All this variety of effect has been produced by different wave lengths; the shorter they are, the more violently they impress themselves on my plate. I am using the long rays of the red light in my dark room, because we call that a "safe light"; it affects the plate very slightly.

In order to bring out these chemical effects, I must use my developer, an oxidizing agent. Then, after a given length of time, I have what we call a negative. Printed on photographic paper, a positive is obtained —the finished picture, with all the shades of contrast, and my image is clear and complete, as I saw it with my eyes.

Now, after this rambling and colloquial introduction, let us consider another, but similar phenomenon. If we take a cadaver, and expose it to the ultra-violet rays, what happens? We have, perhaps, killed a few million germs on the surface of the dead body; but the dead body itself has not been affected. There will be no erythema produced, no increase of calcium, no effect on the stagnated blood.

Effects on the Living Body

The dead body is like my undeveloped film. It needs a *developer* to bring about the effects of the light. That developer is the circulating blood, the normal metabolism, the physiologic processes going on within the living body. The actinic rays are then absorbed, developed, if your please, converted into energy; changes within the body occur, erythema is produced on the skin, the calcium and phosphorus content of the blood is augmented; somehow a life-giving element has been introduced, and has been developed. Powers of resistance have been increased, biologic changes have come about. How is this done? I do not attempt to explain. I do not know exactly how my photographic developer brings into view the latent image on my film.

Is this a fanciful comparison of the light on a photographic plate and the light on a living human body? It may be; but to me it presents a picture of the possible conditions in ultra-violet irradiation, and of its action on the growth and development of all plant and animal life. Dead grass will not turn green from the action of the sunlight The circulating juices of the plant (the developer) are not there to bring out the action of the light.

Without light there is no life. Absence of light may bring on disease; the presence of light, in proper proportion and dosage, may cure disease. That is ultra-violet therapy, the most potent remedial agent, except the sun itself, of which we have knowledge. In health or in disease, therefore, light is necessary.

Pigmentation.—Exposure to ultra-violet rays brings about a change in pigmentation, resulting in increased tolerance to subsequent raying. This seems largely a melanin reaction; the skin appears rather more yellow than dark brown, as from sunlight exposure. It is said that thyroid types usually burn, and adrenal types are more apt to tan, without burning. It seems to depend on the endocrine status of the individual. There is apparently marked endocrine stimulation after a course of ultra-violet.

In ulcers, it must be remembered that the new

Read before the Iowa Radiological and Physiotherapy Society at Des Moines, Iowa, Nov. 12, 1926. Reprinted from *Clinical Medicine* (Vol. 34, No. 2), Feb., 1927.

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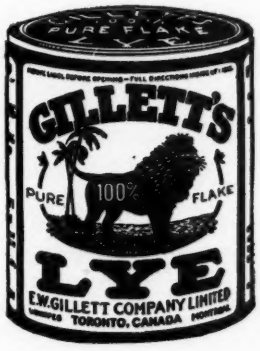

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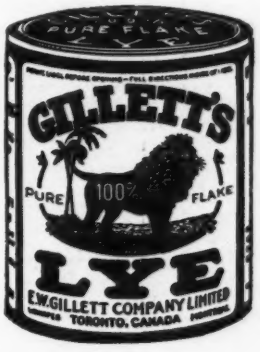

cellular proliferation may be destroyed by over-raying; hence the caution in treating ulcers. The new cells must be old enough to have acquired the toughness that old established epithelium displays. The dosage should not be greatly increased from time to time, and the exposures should be very moderate. In addition, a complete body raying is advisable.

In pregnancy ultra-violet irradiation plays an important role. There is obvious need on the part of the woman for abundant calcium, which is exhausted in the supply to the fetus, and in subsequent lactation. The lack of calcium is apt to start the fetus in life handicapped by a calcium deficiency, with resulting rickets, defective teeth and a variety of disorders. The blood calcium should be from 10 to 11.5 mg. per 100 cc. The lower figures are sometimes found in low *total* blood calcium.

There should be sufficient calcium in the tissue cells, as well as in the blood. Laboratory tests are not the only indications of the clinical picture. Hence in rickets we should not focus our attention on the calcium only; there is also a phosphorus problem. In certain cases the calcium need not be greatly raised, but if phosphorus is increased in the proper proportion, the rickets is healed. Thus there is a true scientific basis for the use of ultra-violet rays in fractures, rickets and pregnancy.

In ultra-violet therapy one must study the technic of exposure, the physiologic effects, the indications and contra-indications. There is abundant current literature on the subject with which every practitioner should familiarize himself. It would seem that we are just at the beginning of our knowledge of the values and action of light. It is a potent therapeutic agent, capable of doing harm, as well as good. When the Creator said; "Let there be light," and the commentator remarked that the light was good, a truth was expressed concerning which we need not change our minds, even in these changing times.

Special Training for Hospital Librarians

That the hospital library is an essential part of the hospital is now becoming generally recognized, and the librarian in charge, to be of greatest benefit to the patient, must be capably trained. Where the hospital is of 200 beds or more the public libraries of the cities generally assign a trained librarian to the individual hospitals. In order to make available special trained librarians for hospital work the University of Minnesota, Minneapolis, Minn., has adopted a course of study for hospital librarians.

The course includes three years of academic work with emphasis upon languages, English courses, social sciences and history. The fourth year is given over almost entirely to library training and the fifth to specialization in hospital needs and practices. The course includes full training in the therapeutic value of reading, hospital library administration, literature for use of hospital groups and field work in the hospital library.—Modern Hospital.

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(a) GENERAL NIGHT DUTY OPEN FOR PROTESTANT R.N.; small Pennsylvania hospital; $85 and maintenance; raise when assured of permanency. (b) New England opening for night supervisor, good disciplinarian; three student nurses assist; 75-bed hospital; $100 and maintenance. (c) Chicago general duty positions open in 85-bed hospital; $90 and maintenance. No. 1369, Aznoe's Central Registry for Nurses, 30 North Michigan Avenue, Chicago.

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REGINA, SASK.—Following a meeting of the medical staff of the Grey Nuns' Hospital recently, it was decided that doctors living outside of the city in the future would be allowed to assist in operations at the Grey Nuns' Hospital. Up till the present, doctors from outside points bringing patients to Regina hospitals have not been able to attend them professionally.

* * *

PALMERSTON, ONT.—As word had been received by the Palmerston Council that the Bill giving Palmerston power to assume the ownership of the Palmerston Hospital had been passed by the Legislature, the matter of the sale of debentures to provide funds for the purchase is in the hands of the Finance Committee, the mayor and clerk.

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DIETETICS

Qualifications of the Dietitian

By LESTER J. PALMER, M.D.

There are many hospitals, averaging in size 100 to 150 beds, which do not employ full-time properly trained dietitians. The purpose of these remarks is to give some reasons why an institution of this size should employ a dietitian, what her qualifications should be, and what the institution, but more particularly the doctor, has a right to expect of her.

University training is essential. A nurse who has spent a few weeks in the dietetic department of one of the well organized or teaching hospitals is not a dietitian. The educational training of a dietitian should be four years of university work. There should be basic training in chemistry, physiology and psychology. The nutrition of health and, for the hospital dietitian, the nutrition of disease should receive special attention. Of course training in general institutional management and teaching are vital subjects. Before taking the responsibilities of a position some at least and as much as possible practical experience should be obtained. Theoretical knowledge should always be crystallized by practical experience.

The possession of the proper type of personality by the dietitian is more than desirable. The personality of some people simply does not permit them to serve food to sick people with any degree of satisfaction. The home training and environment of the dietitian during the years before entering training will influence to a considerable degree her ability to please. To receive a complaint about the food in general or about a specific meal, and to pacify the patient with a smile, to understand the likes and dislikes of sick people who come from the various stratas of society, to encourage on the part of the patient a cheerful acquiescence to the diet orders of the physician, to have the food on the dishes and the dishes on the trays arranged in such a tasteful and attractive manner as to appeal to sick individuals, all of these are much more a matter of instinct than they are of training.

Attractiveness of Food Desirable

It is assumed that with proper educational training the dietitian will easily be able to supply general diets of proper caloric value, that all diets will have proper mineral and vitamine content, will contain correct amounts of fluid and residue and will be properly balanced as to proportions of carbohydrate, protein and fat. But the manner of actual presentation of the physical food to the patient is almost entirely a matter of taste. White trays, either enamelled iron or painted wood, add to the impression of cleanliness. Individual linen for the tray, renewed frequently, makes the difference betwen palatable and unpalatable meals. Food should reach the patient hot if so intended and cold if so intended.

Food cost is one of the smallest costs to the institution in handling a patient. Therefore within the limits of the orders of the physician any food desired by the patient should be supplied. Seasons do not need to be rushed and reason must be exercised. No other single item of service to the patient will create so many boosters for the institution or establish so enviable a reputation for it.

The responsibility of the hospital dietitian should be undivided and complete. She should have full control of all matters pertaining to the feeding of hospital patients and employees. Responsibility should extend to such matters as employing all help in connection with the preparation and serving of food, the storage and preserving of food and the purchasing of food. The general business management may visé the invoices, set the maximum price per meal or per patient-day, confer upon the market and approve the various wholesalers and in these ways contribute valuable co-operations.

Most institutions of the size under discussion have training schools for nurses and not the least of the duties of the dietitian is to act as instructress. This has been sadly neglected in the past. It will not be possible to make this criticism twenty years from now if the small hospital in the near future will correct the conditions existing to-day and place the problems of nutrition in the hands of one of the many excellent dietitians being produced by our numerous universities.

And now I come to what to me is one of the most if not the most important duty of the dietitian in a

Continued on Page 28

From the Virginia Mason Hospital, read before the Northwest Hospital Association, January 4, 1927.

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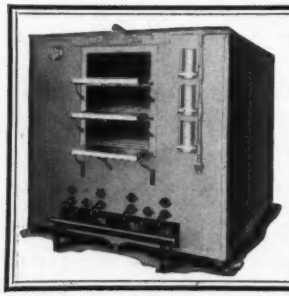
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Qualifications of the Dietitian

Continued from Page 27

hospital of the size under discussion, namely, the teaching of the patient. The hospital of to-day is receiving more and more patients not critically ill, but who seek a haven of rest from the stress and strain of a life filled with hurry and worry. Individuals with functional digestive disturbances or nerve exhaustion, victims of diet fads, undernourished, asthenic people, overweight obese persons, as well as those suffering from organic diseases such as diabetes, hypretension, renal conditions, tuberculosis, the anemias, gastro-intestinal lesions and others, are entering the hospitals for relief. They have faith in the institutions. Many times this faith is poorly placed. For example, a diabetic with tuberculosis is well treated for the tuberculosis in a tuberculosis sanitarium, but the diabetes usually is handled in a very academic manner. Again this faith is often misplaced because it is not enough properly to handle the dietary regime of a nutritional patient during his stay in the institution, but he must be taught while he is there how to carry on after he leaves. True that is more important in some conditions than in others and probably is most important in diabetes. This instruction should be given by the trained dietitian in the modern hospital. It may be directed by the physician, but rarely does he have the time to give it himself.

The dietitian is not qualified and should not be expected specifically to direct the diets of the sick. She should have posted at the station of the head nurse on each floor of the institution a list of the standard diets as they are served and what they contain in that institution so that the physician may know specifically what each standard diet contains. Diabetic diets should be ordered by the physician in grams of carbohydrate, protein and fat. Nephritic diet orders should specify the number of calories and number of grams of protein and whether salt-free or salt-poor. The amount of fluid intake should be specified, whether restricted or forced, and the number of ounces or litres named. Orders for diets, either high or low in calories, should specify the number of calories. The dietitian may post standard specifications to cover many of these points but it is better for the physician to write the prescription for the dietitian to fill. In any event he must not expect or permit the dietitian to write the diet order.

New Emergency Operating Lights

The subject of emergency lighting in the operating room has been given considerable attention within the past few months. Just recently the B.B.T. Corporation of America, Philadelphia, have improved their Type H scialytic emergency operating light so that it is now practical to use it every day as well as an emergency lighting unit.

The Portable Type H Scialytic Emergency Light provides intense illumination for all ordinary operating purposes. In addition, it reduces the annoyance of head shadows and eliminates heat and glare—the special features of the well-known Scialytic surgical operating lights.

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This is accomplished in the same way ordinary radio batteries are recharged, once each month. If preferred, a battery may be furnished complete with trickle charger having three rates of recharging, and both fitted in a single case mounted on the floorstand.

The intensity is practically the same as that of their standard Type F Scialytic light which uses a 100-watt lamp.

Every surgeon and hospital superintendent knows the importance and necessity of being prepared for any emergency in the operating room. Efficient illumination with which an operation may be completed in the event of sudden failure of the electric current, cannot be over-emphasized.

Progressive hospitals, large and small, must be equipped to render service every minute of every hour of every day.

OBITUARY

Donald Campbell Myers

Dr. Donald Campbell Meyers, M.R.C.S., L.R.C.P., London, passed away on April 20th at his residence, 72 Heath Street West, Toronto, after a long illness. He was a leading authority on nervous diseases, which he studied under noted British and European specialists.

In 1894 he established the first hospital in Canada devoted exclusively to the treatment of nervous diseases, which he directed until his retirement in 1920.

Born in 1863 at Trenton, Ont., Dr. Meyers graduated from Trinity Medical College in 1888. He was a friend of and collaborator with the late S. Weir Mitchell, M.D., of Philadelphia, the leading authority in this work in the United States. Through his efforts, wards for the treatment of nervous diseases were started in the old Toronto General Hospital, and were carried on successfully for some years. At one time he was a church warden of St. James' Cathedral and held rank of major in the 10th Regiment, Royal Grenadiers. He was a member of the United Empire Loyalist Society and of the Aesculapian Club, Toronto Club, Toronto Hunt Club, Champlain Society, Empire Club, and a former president of the Glen Major Angling Club. In 1900 he married Edith A., daughter of the late Rev. George and Mrs. Burson, of St. Catharines.

He is survived by his widow, one son, Donald Campbell, and five daughters, Edith, Eleanor, Dorothy, Violet and Mrs. C. S. Eddis; one brother, Walter H. Meyers of Kinistino, Sask.

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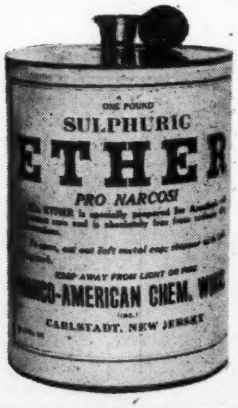

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